

**Vendor Packet – Florida**  
**(Updated October 5<sup>th</sup>, 2020)**  
**Instructions to Vendors**

**Please complete the following:**

- \_\_\_\_\_ 1. Vendor Information Sheet (U-5)  
(Please complete form and attach all applicable licenses)
  
- \_\_\_\_\_ 2. W-9 (Rev-2017) New October 2018 – Form Attached  
(Please complete form)
  
- \_\_\_\_\_ 3. Insurance Requirements (A-8i)  
(Please complete and sign form)
  
- \_\_\_\_\_ 4. Sample Insurance Certificate (A-8j)
  - a) Give this sample to your agent
  
  - b) Have agent submit your certificate directly to:  
*vendors@flynmanagement.com*
  
- \_\_\_\_\_ 5. Workers Comp Statement (A-8f)  
(Complete form by checking only 1 option and submit  
Florida Worker’s Comp Exemption Card if option #1 was  
selected)

**Return completed forms to [vendors@flynmanagement.com](mailto:vendors@flynmanagement.com)**

If you have any questions, please contact Sandy Dorval at (727)449-1182 x214

## ATTACHMENT "C"

PROPERTY NAME: \_\_\_\_\_  
 CONTRACTOR/VENDOR INFORMATION SHEET – Form #U-5

**A. The legal name and business address of the Contractor/Vendor is:**

Business Name: \_\_\_\_\_

D/B/A: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Principal: \_\_\_\_\_ Salesman: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Number of Employees: \_\_\_\_\_ Are employees direct or leased: \_\_\_\_\_

**B. The Contractor/Vendor is:**

1. Corporation Yes: \_\_\_\_\_ No: \_\_\_\_\_

2. Other: \_\_\_\_\_

3. Federal I.D. Number: \_\_\_\_\_

4. FL or GA Dept. of Professional Reg. License (Attach Copy): \_\_\_\_\_

FDPR Qualifying Individual Name: \_\_\_\_\_

5. Local Occupational License Number (Attach Copy): \_\_\_\_\_

**C. The name, title, and address of the owner, partners or officers of the Contractor/Vendor firm are:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Home Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**D. Business References:**

Company	City	Contact Person	Phone
_____	_____	_____	_____

**E. Insurance Agency - Liability: \_\_\_\_\_**

Agent Name: \_\_\_\_\_ Agent Phone Number: \_\_\_\_\_

Agent Email: \_\_\_\_\_

ATTACHMENT "C"

PROPERTY NAME: \_\_\_\_\_  
CONTRACTOR/VENDOR INFORMATION SHEET – Form #U-5

F. Insurance Agency – Workers Comp: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Agent Phone Number: \_\_\_\_\_

Agent Email: \_\_\_\_\_

G. Payment Terms (Please initial each item)

\_\_\_\_\_ All invoices will be submitted directly to the property after the work has been completed

\_\_\_\_\_ All invoices will be billed in the name of the property to which the service(s) were rendered

\_\_\_\_\_ All payments will be made within 30-days of the invoice being submitted in accordance of the above

I hereby certify that this information is correct and authorize verification by Flynn Management Corporation of its agents.

Date: \_\_\_\_\_

\_\_\_\_\_  
Contractor/Vendor

By: \_\_\_\_\_

Title: \_\_\_\_\_

Please list all Flynn Management properties where you desire to perform services:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# REQUIREMENTS FOR CONTRACTORS AND SUBCONTRACTORS

*The following specifications for subcontractors or contractors are intended to provide proper protection. These are considered minimum requirements, and it is the Subcontractor's or Contractor's responsibility to maintain adequate protection.*

## I. Minimum Coverage and Limits for both Contractors and Subcontractors

### A. General Liability Coverage

1. \$500,000 Combined Single Limit of Liability for Bodily Injury and Property Damage.
2. Comprehensive Coverage Including:
  - a) Personal Injury
  - b) Blanket Contractual Coverage
  - c) Employees as Additional Insured's
  - d) Completed Operations/Products
  - e) XCU Coverage

### B. Workers Compensation Coverage Including:

1. Coverage B at a Limit of at Least \$100,000/\$500,000/\$100,000
2. All State Endorsements

### OR

1. Worker's Compensation Exemption Certificate meeting all current State and Federal Laws.

### C. Automobile Liability Coverage

1. Automobile Liability coverage all owned, leased, hired and non-owned autos.

## II. All Contractors or subcontractors must provide Certificates of Insurance to Owner prior to their working, demonstrating they meet the requirements.

## III. It is **required** to have all Contractors and subcontractors name Flynn Management Corporation and **property owner** as an "Additional Insured" onto the Contractor's and subcontractor's general liability, auto and umbrella policies. See attached sample "Certificate of Liability Insurance" form.

All applicable insurance certificates must be emailed to the following address:

[vendors@flynnmanagement.com](mailto:vendors@flynnmanagement.com)

If your auto insurance is not included with your General Liability insurance, please also submit a copy of your auto policy declaration page.

It is the responsibility of the vendor to provide updated / renewal certificates to continue to work on all Flynn Management properties.

Vendor Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

**CERTIFICATE OF LIABILITY INSURANCE**

DATE (MM/DD/YYYY)

4/17/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER SPECIMEN CERTIFICATE	CONTACT NAME:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
INSURED SPECIMEN CERTIFICATE - Sample Purpose Only SPECIMEN CERTIFICATE - Sample Purpose Only	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

**COVERAGES**

CERTIFICATE NUMBER: 12957314

REVISION NUMBER: See below

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
X	COMMERCIAL GENERAL LIABILITY CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			XXXXXX	05/01/2018	05/01/2019	EACH OCCURRENCE \$ 100000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100000 MED EXP (Any one person) \$ 5000 PERSONAL & ADV INJURY \$ 100000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2000000 EBL \$ 1,000,000
	AUTOMOBILE LIABILITY ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> X HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY <input type="checkbox"/>			XXXXXX	05/01/2018	05/01/2019	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
X	UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$			XXXXXX	05/01/2018	05/01/2019	EACH OCCURRENCE \$ 15,000,000 AGGREGATE \$ 15,000,000 \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y/N N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

SPECIMEN CERTIFICATE - Sample Purposes Only

**CERTIFICATE HOLDER**

Flynn Management Corporation  
516 Lakeview Road Ste 8  
Clearwater, FL 33756

**CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



# FLYNN MANAGEMENT CORPORATION



## STATEMENT OF WORKERS COMPENSATION - FLORIDA

\_\_\_\_\_  
Vendor

\_\_\_\_\_  
Trade

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Check one of the following three options:

\_\_\_\_\_  
**1. State Exemption Card** - I have an exemption of workers compensation coverage pursuant to Florida Statute, Chapter 440.

\_\_\_\_\_  
**2. Insurance Policy** - I have a current workers compensation policy. A certificate of insurance will be provided.

X

\_\_\_\_\_  
Vendor Signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title